| Department of Human Resources<br>311 West Saratoga Street<br>Baltimore MD 21201 | **Family Investment Administration**<br>**ACTION TRANSMITTAL** |
|---|---|
| **Control Number:** #11-28 | **Effective Date: UPON RECEIPT**<br>**Issuance Date:** May 20, 2011 |

**TO:** **DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES**
**DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT**
**FAMILY INVESTMENT SUPERVISORS AND CASE MANAGERS**

**FROM:** **ROSEMARY MALONE, INTERIM EXECUTIVE DIRECTOR, FIA**
**ROLF GRAFWALLNER, ASSISTANT STATE SUPERINTENDENT, DECD, MSDE**

**RE:** **NEW MEDICAL REPORT FORM DHR/FIA 500**

**PROGRAMS AFFECTED:** **FOOD SUPPLEMENT PROGRAM (FSP), TEMPORARY CASH ASSISTANCE (TCA), REFUGEE CASH ASSISTANCE (RCA) AND TEMPORARY DISABILITY ASSISTANCE PROGRAM (TDAP), CHILD CARE SUBSIDY, (CCS) PUBLIC ASSISTANCE TO ADULTS (PAA)**

**ORIGINATING OFFICE:** **OFFICE OF PROGRAMS**

**Background:**

Action Transmittal 11-13 outlined the referral procedures for applicants and recipients filing for disability in an Aged, Blind or Disabled Medical Assistance coverage group. It also eliminated the DHR/FIA Medical Report form (402 B) for **Medical Assistance and State Review Team referrals only.** Family Investment Administration (FIA) programs and the Child Care Subsidy program use the 402B to determine a customer's disability and the need to apply for Supplemental Security Income (SSI) or the customer's ability to participate in work activities.

A new medical report form has been created. The new form incorporates all information case managers need when determining disability for TCA, RCA, TDAP, CCS and PAA applicants or recipients. The DHR/FIA 500 combines several forms and obsoletes the need to use the DHR/FIA 402B, the DHR/FIA 402W and the Physician's Report of Eye Examination, the DHR/FIA 701 for FIA programs.

**ACTION DUE:**

The LDSS may begin to use the new DHR/FIA 500 form immediately upon receipt from the DHR warehouse. Issuance and use of the new form does not change any existing Program policy or CARES procedures. The new DHR/FIA 500 Medical Report Form will also be available under FORMS on FIPNET.

**As a reminder:** Continue to follow SRT requirements for MA as provided in Action Transmittal 11-13 issued December 13, 2010, when referring a customer to SRT. LDSS case managers must submit the following forms in order to make a referral for SRT disability determination.

**SRT Referral Packet:**

- DHR/FIA 700 Customer Declaration of Disability
- DHR/FIA 827 Authorization to Release Information
- DHR/FIA 3368 Disability Report
- OES 06 Substantial Gainful Activity (SGA) Worksheet
- DHR/FIA 707 Disability or Blindness Determination

**INQUIRIES:**

Direct FSP questions to Rick McClendon at 410-767-7307 or rmcclend@dhr.state.md.us and TCA ,TDAP and RCA questions to Marilyn Lorenzo at 410-767-7333 or mlorenzo@dhr.state.md.us or to Gretchen Simpson at 410-767-7937 or gsimpson@dhr.state.md.us. PAA and RMA questions should be directed to Deborah Weathers at 410-767-7994 or dweather@dhr.state.md.us. SRT questions should be directed to Cynthia Carpenter at 410-767-8910 or ccarpent@dhr.state.md.us. Child Care Subsidy questions should be directed to Myra White-Gray @ 410-767-7863 or myrawhite-gray@msde.stat.md.us.

cc: DHR Executive Staff
FIA Management Staff
Constituent Services
Policy and Training Staff
MSDE-DECD

_____Department of Social Services

**MEDICAL REPORT FORM 500**

Local District Office: _____ Date: _____

Case Manager: _____ Phone Number: _____

Customer's Name: _____ Customer ID#: _____

The information provided on this form may be used to determine eligibility for federal and State programs and participation in employment or training programs.

A. **Patient Information:**

Name of Patient: _____ Date of Birth: _____

Address: _____

Dates of Examinations: First Visit: _____ Last Visit: _____

Presenting Symptoms: _____

_____

_____

**B. Physical Limitations:**

In terms of the patient's ability to perform work during an 8-hour day **or** attend classes **or a** training activity with normal breaks, the patient can:

| Activity | Unknown | No Restrictions | Never | 1 hr | 2 hrs | 3 hrs | 4 hrs | 5 hrs | 6 hrs | 7 hrs | 8 hrs |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Sit | | | | | | | | | | | |
| Stand | | | | | | | | | | | |
| Walk | | | | | | | | | | | |
| Climb | | | | | | | | | | | |
| Bend | | | | | | | | | | | |
| Squat | | | | | | | | | | | |
| Reach | | | | | | | | | | | |
| Crawl | | | | | | | | | | | |

Circle the **HEAVIEST** weight the patient can lift/carry.

Less than 10 lbs. 10 lbs. 20 lbs. 25 lbs. 50 lbs. 100 lbs. More than 100 lbs.

How do environmental factors such as dust, chemicals, heat and cold, limit the patient's activities? _____

_____

_____

_____

Is substance abuse present? ☐ **YES** ☐ **NO**

If yes, do other medical conditions exist in addition to substance abuse? ☐ **YES** ☐ **NO**

**C. Mental Status Information:**

Does the patient suffer from a mental illness? ☐ **YES** ☐ **NO**

To the best of your knowledge does the patient have any learning disabilities? ☐ **YES** ☐ **NO**

To the best of your knowledge, does the patient exhibit any violent behaviors? ☐ **YES** ☐ **NO**

If yes, please provide additional information at the end of this form.

Does the patient have an impairment or combination of impairments that interfere with his or her ability to function independently, appropriately and effectively on a continuous basis? **YES_____ NO _____**

Does the patient have a visual impairment or disease that limits or interferes with his or her ability to function independently, appropriately and effectively on a continuous basis? **YES_____ NO____**

| **FUNCTIONAL LIMITATIONS (degree of restriction or difficulty)** | **DEGREE OF LIMITATION** | | | |
|---|---|---|---|---|
| Daily living activities | ☐ None | ☐ Mild | ☐Moderate | ☐ Extreme |
| Maintaining social functioning | ☐ None | ☐ Mild | ☐ Moderate | ☐ Extreme |
| Maintaining concentration | ☐ None | ☐ Mild | ☐ Moderate | ☐ Extreme |

Based upon your evaluation, has the patient's medical condition or visual impairment been on-going? **YES_____ NO____**

Can it be expected to last at least 12 months or more? **YES ☐ NO ☐**

**If yes, please give the length of time the patient's medical condition is expected to last.**

_____/_____/_____ To _____/_____/_____
Month Day Year Month Day Year

Is the patient's medical condition expected to result in death? **YES ☐ NO ☐**

Does the patient's medical condition or visual impairment limit his or her ability to work? **YES ☐ NO ☐**

If **yes**, please give the duration. _____/_____/_____ To _____/_____/_____
Month Day Year Month Day Year

Does the impairment limit the patient's ability to attend school or training? **YES ☐ NO ☐**

If **yes**, please give the duration._____/_____/_____ To _____/_____/_____
Month Day Year Month Day Year

If yes, provide the number of hours the patient's participation in work, school or training will be limited to per day: _____

**D.** If this medical form is being completed for a child, does the child's condition require the parent to be in the home full time to provide care for the child? **YES ☐ NO ☐**

**E. Additional Comments:**_____

_____

_____

Signature:_____ Print Name:_____

Title:_____ License #:_____

Medical Practice Name and Address: _____

_____

MA Provider#:_____ Federal ID # or Social Security #: _____

Date: _____